**Authorization Form – Evaluation/Assessment/Teaming**

Missouri First steps EARLY INTERVENTION

Child's Name:_____D.O.B. _____

Provider(s) Information:

Service Provider(s)/Billing Entity

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Start Date of Service_____ End Date of Service: _____

Number of Minutes needed: _____

- ☐ Evaluation/Assessment/Structured Observation – Eligibility
- ☐ Evaluation/Assessment/Structured Observation –IFSP Planning
- ☐ Transition Meeting
- ☐ Eligibility Team Meeting
- ☐ IFSP Team Meeting

Requested by:_____ Date: _____

Data Entry by:_____ Date: _____

March 03

# AUTHORIZATION FORM INSTRUCTIONS

***Purpose*:** This form is used by System Point of Entry [SPOE] personnel and on-going service coordinators to authorize early intervention services NOT included on a child's Individualized Family Service Plan [IFSP]. The services include all teaming, evaluation, assessment and structured observation activity. The form is generally faxed to the SPOE, which is responsible for data entry and submission to the Central Finance Office.

***Child's name:*** Should be the legal name of the child.

***DOB:*** Child's date of birth

***Provider Information:*** Please complete this section carefully. This should tell the SPOE which provider is performing the service and who should be paid. Care should be taken if a provider has more than one payment arrangement within the system. Indicate if the person is with an agency or independent and if with an agency the agency name. Multiple providers can be listed on one form ONLY if they are being authorized for the same activity and same amount of time for the activity.

***Early Intervention Service:*** Please select from the following list:

| | | |
|---|---|---|
| Assistive Technology Device | Nursing Services | Social Work/Counseling |
| Audiology | Nutrition Services | Services |
| Health Services | Occupational Therapy | Special |
| Interpreter services (bilingual) | Physical Therapy | Instruction/Developmental |
| Interpreter services (sign) | Psychological Service | Therapy |
| Medical Services | Coordination | Speech Language Pathology |
| | Service Coordination | Vision Services |

***Location:*** Use Home; Other Family Location; Community Setting; or Special Purpose Center or Clinic

***Start date:*** Should represent a forward date and may be in advance of the actual planned event to allow the authorization to occur even if re-scheduling is necessary.

***End date:*** No more then 30 days unless there are extenuating circumstances that are noted in the comments field. Can not be a date past current IFSP end date.

***Number of Minutes needed:*** This is intended to be the maximum duration of the authorization. Typical authorizations for these activities range from 60 to 120 minutes in duration.

**Check Box:** Please check the service activity covered by this authorization form. Note: IFSP team meeting includes: initial, annual, 6-month review, periodic review meetings. Separate authorization forms will be used for different activities. IEP meetings held by the local district for children transitioning to Part B (ECSE) are not paid for by Part C and cannot be authorized with this form. Transition meeting should only be used for the required meeting conducted by the Part C system at age 2 years 6 months.